STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	07/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF FT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure. This visit included the investigation of complaints IN00091583, IN00092054 and IN00092602. Complaint IN00091583 Substantiated, Federal/State deficiencies related to the allegations are cited at F309 and F514. Complaint IN00092054 Substantiated, Federal/State deficiencies related to the allegations are cited at F514. Complaint IN00092602 Unsubstantiated, due to lack of evidence. Survey Dates: June 27, 28, 29, 30 and July 1, 2011 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Survey team: Angela Strass, RN TC Ann Armey, RN (June 27 & 28, 2011) Rick Blain, RN Sue Brooker, RD Sheryl Roth, RN Census bed type:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 149 Total: 149 Census payor type: Medicare: 12 Medicaid: 104 Private: 11 Other: 22 Total: 149 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/7/11 Cathy Emswiller RN			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was accurate for the immunization history for 1 of 24 residents reviewed for MDS accuracy. (Resident #123) Findings include:	F0272	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of	07/31/2011

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	Resident #123's record was reviewed on 6/28/11 at 9:50 a.m. The record indicated Resident #123's diagnoses included, but were not limited to, heel ulcer, dementia, and lymph edema. The "Pneumococcal Polysaccharide Vaccine (PPV) Education Sheet," dated 2/18/10, indicated Resident #123 gave permission and was requesting the PPV vaccination. The "Immunization Record" for Resident #123 indicated the resident received the PPV vaccine on 2/24/10 in the left arm (deltoid). A second "Immunization Record" was also located in the clinical record with no name listed but indicated the resident received the PPV vaccine on 3/10/11 in the right thigh. The annual MDS for Resident #123, dated 2/23/11, contained the following information: "Is the resident's Pneumococcal vaccination up to date?" The question was marked no. "If Pneumococcal vaccine not received, state reason." The question was marked with a hyphen. The choices included: not eligible, offered and declined and not offered. During an interview with the Director of Nursing on 6/27/11 at 11:00 a.m., she		federal and state law. **F272** 1. Resident #123 did receive the PPV vaccine. Resident #123's physician was notified of resident receiving the PPV twice with no concerns voiced and no new orders received. The MDS for Resident #123 has been modified to reflect current, accurate PPV status. 2. All resident MDS' have been audited to determine coding for PPV with modifications made to the MDS' as necessary. 3. Licensed nursing staff responsible for completion of the MDS will receive in-service education relative to accurate coding of the MDS related to Pneumococcal vaccination status. A performance improvement tool has been developed that DNS, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, accurate coding of the MDS related to Pneumococcal vaccination status. 4. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.	

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	indicated the MDS nurse may have read it wrong. She further indicated it should have been marked current if the resident had the immunization. 3.1-31(d)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure nursing staff assessed 1 of 1 residents on dialysis before and/or after hemo-dialysis (#128) to rule out dialysis complications, and failed to ensure 1 resident (C) received a medication as ordered in a sample of 24 resident records reviewed. Findings include: 1. Resident #128's record was reviewed on 6/30/11 at 10:30 a.m. The record indicated Resident #128's diagnoses included, but were not limited to, end stage renal disease and diabetes mellitus.	F0309	**F309** 1. a. Please note that Resident #128 incurred no negative outcome as a result of this practice. A Dialysis Log has been placed in the Medication Administration Record (MAR) book for Resident #128. b. Please note that Resident C incurred no negative outcome as a result of not receiving the suppository as ordered. Resident C's physician has been notified with no concerns voiced. 2. An audit has been conducted of the MARs and Treatment Administration Records (TAR) for all residents to ensure Dialysis Logs are present for all residents receiving Hemodialysis, and to ensure that all medications are	07/31/2011

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	An interview was conducted with RN #15 on 6/27/11 at 10:40 a.m. During the interview, RN #15 indicated Resident #128 was currently at the dialysis center and that she goes there every Monday, Wednesday and Friday. Review of the nurse's notes for Resident #128 from 12/31/10 through 6/5/11, contained no complete pre/post (before/after) dialysis assessments. The Director of Nursing (DON) provided copies of February, March, April, and May 2011 dialysis logs for Resident #128 on 7/1/11 at 9:50 a.m. During interview the DON indicated at that time, she was unable to find the dialysis log for June 2011. The dialysis log for February 2011 for Resident #128 was missing pre-dialysis assessments 6 of 12 days (February 2, 4, 14, 18, 21, 23). The log had missing post-dialysis assessments 8 of 12 days (February 2, 4, 14, 16, 18, 21, 23, 28) and the post-dialysis assessment on February 7 was incomplete. The dialysis log for March 2011 for Resident #128 indicated dialysis days were Monday, Wednesday and Friday. The log was missing pre-dialysis		being administered according to physician orders. Any identified concerns will be addressed with the responsible individuals. 3. Licensed nursing staff shall receive in-service education relative to provision of care/services, including but not limited to pre/post dialysis assessments with documentation of the same; and administration of medication in accordance with physician orders and documentation of medication administration and/or refusal of medications by residents. 4. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.	

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	assessments 12 of 12 days (March 2, 4, 7, 9, 11, 14, 16, 18, 21, 23, 25, 28). The log had missing post-dialysis assessments 12 of 12 days (March 2, 4, 7, 9, 11, 14, 16, 18, 21, 23, 25, 28). Pre-dialysis assessments were listed on days other than Monday/Wednesday/Friday five times and there was only one post dialysis assessment listed for the entire month and it was on a Tuesday. An undated dialysis log for Resident #128 listed pre-dialysis assessments ten times for the month with no post dialysis assessments. The dialysis log for May 2011 for Resident #128 indicated dialysis days were Monday, Wednesday, and Friday. The log was missing pre-dialysis assessments 8 of 13 days (June 2, 11, 13, 16, 18, 20, 27, 30). The log had missing post-dialysis assessments 12 of 13 days (June 2, 4, 6, 9, 11, 13, 16, 18, 20, 23, 27, 30). On 6/30/11 at 3:15 p.m., the DON provided the Hemodialysis Policy, dated 10/31/09. During the interview at that time, she indicated the policy was the one currently used by the facility. The policy included, but were not limited to, "...assist resident in maintaining homeostasis and to assess and maintain patency of the			

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	hemodialysis access...pre-dialysis care...listen over the fistula with a stethoscope to detect a bruit (swishing noise)...assess for signs of infection...weight resident unless obtained from the dialysis center...communicate to the dialysis unit: medications given in the last 6 hours prior to being sent...post-dialysis care...access for patency and any unusual redness or swelling...check bandage and leave in place for at least 4 hours after treatment or longer if the needle site continues to ooze...assess the access site upon return from dialysis for: bleeding from the site...." 2. Review of the clinical record for resident (C) on 6/28/11 at 9:45 a.m. indicated the resident had diagnoses including but not limited to, Parkinson's disease, chronic pain, and left sided hemiparesis. Review of the resident's list of medications indicated an order for "Anu-Med suppository" to be given twice daily One on first and second shift. The Medication Administration Record (MAR) for June 2011 indicated no signatures of the resident receiving the suppository on the second shift for June 1,			

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	9, 19, 25, 26, 28 & 30. The record also indicated that on second shift the treatment record had been signed and circled (indicating the resident did not receive the medication) on June 2, 3, 4, 5, 6, 7, 11, 13, 15, 20, 26 and 29. There were two entries made on the back of the record which indicated on 6/20/11 the resident had refused, and on 6/29/11 the documentation indicated "Resident still up at shift change". Interview with the resident on 6/29/11 at 11:00 a.m. indicated that he does not always get the suppository on second shift. Interview with the Director of Nursing on 6/30/11 at 1:30 p.m. indicated she knew about the problem and had written a "complaint/grievance" form related to the issue. Review of the form indicated it was dated 6/13/11. This Federal tag relates to complaint IN00091583 3.1-37(a)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review the facility failed to ensure the physician provided clinical justification for no gradual dose reduction for a psychotropic medication for 1 resident (Resident #44) of 12 residents reviewed with psychotropic medications in a sample of 24. Findings include: Review of the clinical record for Resident #44 on 6/30/11 at 9:55 a.m., indicated the following: diagnoses included, but were not limited to, personality disorder.	F0329	**F329** 1. Physician of resident # 44 was notified of non-compliance and informed of regulation and facility policy. Identified resident's psychotropic medications were reviewed to ensure complaince of physician's justification for no gradual dose reductions - all are compliant. 2. In an effort to identify any other residents potentially similarly affected, DNS has completed a facility wide audit of resident pharmacy recommendations to ensure clinical justification is present for any declined attempts at gradual dose reduction. Any identified concerns were corrected at the time of discovery. 3. Licensed nursing staff and	07/31/2011

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	A physician's order summary sheet for Resident #44, for the month of September, 2010, indicated Clonazepam 1 mg (milligram) TID (three times a day). A "Consultant Pharmacist's Recommendation To Inter-Disciplinary Team (IDT)", dated 3/29/11, indicated "...This resident has been on Klonopin 1 mg TID. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose. The comments below may assist you in the documentation process. Please check the appropriate response and add additional information as requested: ...." The resident's physician placed an "x" next to the statement "...Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because psychiatric instability. (Please elaborate with patient specific information): ..." The physician did not provide clinical rationale on the pharmacy form to justify the continuation of the Klonopin at the same dosage. The Director of Nursing was interviewed on 6/30/11 at 3:45 p.m. During the interview she indicated the physician was expected to provide justification for no gradual dose reduction on the pharmacy		Social Services staff have received in-service education relative to ensuring drug regimens are free from unnecessary drugs, including but not limited to ensuring that physician has provided clinical justification for not attempting a gradual dose reduction, when appropriate. A letter has been provided to physicians communicating to them that they must provide clinical justification when they decline a gradual dose reduction attempt. Additionally, DNS has spoken with physicians regarding the same to ensure their understanding. A performance improvement tool has been developed that DNS, ADNS, UM, or designee, will utilize to monitor weekly times 4 weeks ensuring provision of clinical justification for any denied gradual dose reduction attempts. Any identified concerns will be discussed with the responsible physician with corrective action implemented, as necessary. 4. DNS, ADNS, UM, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.	

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	recommendation form. She also indicated the facility has discussed with the physician the need to provide written justification to pharmacy recommendations in the past. A current facility policy "Unnecessary Drugs", dated 4/28/10, indicated "...Medications are tapered to find an optimal dose or to determine whether continued use of the medication is benefiting the resident...During the monthly medication regimen review, the pharmacist evaluated the resident-related information for dose, duration continued need, and the emergence of adverse consequences for all medications...When evaluating the resident's progress, the practitioner reviews the total plan of care, orders, the resident's response to medication(s), and determines whether to continue, modify, or stop a medication...." 3.1-48(b)(2)			
F0386 SS=E	The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.			

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	Based on record review and interview, the facility failed to ensure all physician orders were dated for 6 of 24 residents reviewed with physicians orders in a sample of 24. (Resident #44, #42, #99, #114, #123 and #129) Findings include: 1. Review of the clinical record of Resident #44 on 6/30/11 at 9:55 a.m., indicated the following: diagnoses included, but were not limited to, obstructive sleep apnea, congestive heart failure, chronic airway obstruction, and diabetes mellitus. The following telephone orders were noted in the chart of Resident #44. Each completed telephone order contained the signature of the physician, but did not contain the date when the order was signed by the physician: On 3/19/11 - Ceftin 250 mg (milligrams) po (orally) BID (twice a day) for 10 days related to UTI (urinary tract infection). Undated by nursing - D/C (discontinue) Coumadin 6 mg QD (every day). Start Coumadin 7 mg QD. Re-check in 1 week. On 4/1/11 - Decrease Cymbalta to 15 mg QD per pharmacy recommendation et	F0386	**F386** 1. The telephone orders for Resident #s 44, 42, 99, 114, 123 and 129 were reviewed, validated, and corrected by ordering physician. 2. In an effort to identify any other residents potentially similarly affected a facility wide chart audit has been conducted. Any identified concerns were addressed with responsible individuals. 3. Licensed nursing staff and Medical Records staff have received education relative to physician visits – Review Care/Notes/Orders, including but not limited to ensuring physician orders are dated by the nurse receiving telephone orders and by the physicians during visits to facility. A letter has been provided to physicians communicating to them that they must date all of their orders. Additionally, DNS has spoken with physicians regarding the same to ensure their understanding. A performance improvement tool has been developed that ADNS, UM, Medical Records staff, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, that physicians orders have been dated. Any concerns will be promptly addressed with responsible individuals. 4. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring	07/31/2011

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	(and) MD agrees. On 4/1/11 - Claritan 10 mg po QD x (times) 10 days for allergy. On 4/1/11 - D/C Cymbalta 15 mg QD. Cymbalta 20 mg po QD for anxiety. On 4/4/11 - Continue same dose Coumadin 7 mg Q (every) day. Recheck. On 4/11/11 - Continue Coumadin 7 mg. Recheck PT/INR (blood test for clotting time) again in 2 weeks. On 4/13/11 - Repeat UA (urinalysis) C+S (culture and sensitivity) if indicated related to c/o (complaints of) burning. On 4/17/11 - Macrobid 100 mg BID x (times) 7 days related to UTI. On 4/25/11 - Continue Coumadin 7 mg po QD. PT/INR in 2 weeks. On 4/26/11 - D/C Talwin NX 50 mg 1 po Q 4 hours prn (as needed). Talwin NX 50 mg 1 po QID Q 4 hours prn and NOC (night) pain. On 4/27/11 - OT (Occupational Therapy) to eval and treat for right arm et right arm edema.		thereafter.	

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	On 5/7/11 - Obtain U/A C+S if indicated related to c/o's dysuria (difficult urination), hx (history) UTI. On 5/9/11 - No new orders. Continue current Coumadin 7 mg dly (daily). Recheck PT/INR 2 wks (weeks). On 5/26/11 - Clarification order: D/C 100 mg Vit B complex. Start Vit B complex 50 mg BID. On 6/4/11 - D/C Estrace cream 1 gm (gram) vaginally QD x 2 weeks then 3 x wkly. On 6/6/11 - Continue Coumadin 7 mg po QD. Recheck PT/INR in 2 weeks. On 6/13/11 - D/C order to straight cath for urine culture. May obtain clear catch urine specimen for U/A C+S if indicated. On 6/16/11 - Refer to gynocology (sic) consult for vaginal bleeding. On 6/16/11 - Celftin 250 mg po BID x 10 days. On 6/20/11 - Continue Coumadin 7 mg po QD. Recheck PT/INR 7/4/11. 2. Review of the clinical record of Resident #42 on 6/29/11 at 9:56 a.m.,			

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	155249	A. BUILDING 00 B. WING	07/01/2011

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	indicated the following: diagnoses included, but were not limited to, dementia with behavioral disturbance, and attention deficit with hyperactivity. The following telephone orders were noted in the chart of Resident #42. Each completed telephone order contained the signature of the physician, but did not contain the date when the order was signed by the physician: On 12/30/10 - D/C Phenergan 25 mg IM (intramuscular) Q 6 hours prn/non-usage. On 4/28/11 - Nystatin cream to groin excoriation Q shift x 14 days. Re-evaluate. On 5/24/11 - D/C Nystatin crm (cream) to groin excoriation. Apply critic aid cream to groin, buttocks et bilateral upper thighs Q shift. On 6/13/11 - D/C critic aid to groin, buttocks + bilateral upper thighs Q shift. Apply critic aid to buttocks + peri area Q shift + pm. Apply nystatin cream to bilateral inner thighs Q shift + pm x 30 days. Re-evaluate. The Director of Nursing was interviewed on 6/30/11 at 3:45 p.m. During the interview she indicated the physician was			

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	expected to sign and date all orders. She also indicated the facility has discussed with the physician the need to date his orders in the past. A current facility policy "Verbal/Telephone Orders", dated 1/15/10, indicated "...Obtain physician's signature on the telephone order and place the signed telephone on the resident's medical record...." The policy did not indicate the telephone order should contain the date when the physician signed the order. 3. The record for Resident #99 was reviewed on 6/28/11 at 4:30 P.M. The following physician orders were signed and dated by the nurse and were signed by the physician, but were not dated by the physician: 5/26/11: A clarification order for xeroform (petroleum) gauze to a coccyx wound daily. 5/30/11: An order to start morphine sulfate (pain medication) every 2 hours as needed and for Lasix (diuretic medication) one dose only. 6/6/11: An order to hold Coumadin			

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	(blood thinner) and to administer one dose of vitamin K intramuscularly and to obtain lab work. 6/7/11: An order to change the dose of Coumadin and to obtain lab work. 6/9/11: An order to change the dose of Coumadin. The Physician's Orders monthly re-cap for June 2011 were signed by the physician, but not dated. 4. The record for Resident #114 was reviewed on 6/30/11 at 10:00 A.M. The following physician orders were signed and dated by the nurse and were signed by the physician, but were not dated by the physician: 3/25/11: An order to obtain lab work. 3/31/11: An order to change the dose of Dilantin (medication to treat seizures) and to obtain lab work. 4/5/11: An order to obtain a referral to a psychologist. 4/19/11: An order to allow weight bearing as tolerated.			

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	6/11/11: An order to apply Bacitracin ointment to a wound. The Physician's Orders monthly re-cap for June 2011 were signed by the physician, but not dated. 5. Resident #123's record was reviewed on 6/28/11 at 9:50 a.m. The record indicated Resident #123's diagnoses included, but were not limited to, dementia, high blood pressure, dysphagia (difficulty swallowing) and peripheral vascular disease. The following signed physician orders were undated as to when they were signed: - Telephone order for coumadin (blood thinner) change was undated by the physician and the nurse (on the same sheet as orders dated 6/6/11 and 6/7/11) - Telephone order for coumadin change was undated by the physician and the nurse (on the same sheet as orders dated 6/8/11)			

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	- Telephone order for coumadin change, dated 4/2/11 - Telephone order for blood draw, dated 4/4/11 - Telephone order for coumadin, dated 4/4/11 - Telephone order for elevating legs, dated 4/13/11 - Telephone order for dressing change, dated 5/4/11 - Telephone order for pain medication, dated 5/4/11 - Telephone order for dressing change, dated 5/5/11 - Telephone order for dressing change, dated 5/24/11 - Physician's Orders monthly rewrite, dated 5/30/11 - Telephone order for dressing change, dated 6/7/11 - Telephone order for dressing change, dated 6/8/11 - Telephone order for adding a diagnosis,			

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	dated 4/13/11 6. Resident #129's record was reviewed on 6/28/11 at 1:15 p.m. The record indicated Resident #129's diagnoses included, but were not limited to, cerebrovascular accident (stroke), diabetes mellitus, chronic obstructive pulmonary disease and high blood pressure. The following signed physician orders were undated as to when they were signed: - Physician's Orders monthly rewrite, dated 4/26/11 - Telephone order for dressing change, dated 5/24/11 - Physician's Orders monthly rewrite, dated 5/26/11 - Telephone order for dressing change, dated 6/14/11 3.1-22(c)(3)			

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F0514 SS=E	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interviews and record review, the facility failed to ensure discharge information was complete for 1 of 1 residents reviewed, who transferred to another extended care facility, (resident B) and failed to file the most recent PreAdmission Screening Determination (PASAAR) for Resident #137 and wound note for (Resident #123) and failed to document why a resident did not receive a medication (Resident C) in a sample of 24 resident records reviewed. Findings include: 1. The clinical record of resident #B was reviewed on 6/27/11 at 11:00 a.m., and indicated the resident was admitted to the facility on 5/20/11, with diagnoses which included but were not limited to, left shoulder fracture, alcohol dementia, post	F0514	**F514** 1. a. Resident #B has been discharged from the facility, therefore, no corrective action could be taken for this resident. b. Please note that Resident C incurred no negative outcome as a result of not receiving the suppository as ordered. Resident C's physician has been notified with no concerns voiced. c. As is stated on page 21 of the 2567, the wound care note was obtained from the wound clinic at the time of survey. This note was placed on the medical record and provided to ISDH surveyor. Resident incurred no negative outcome as a result of the wound care note not being on the chart. d. As is stated on page 21 of the 2567, the PASRR documentation was obtained from the Social Worker at the time of survey. This PASRR documentation was placed on the medical record and provided to ISDH surveyor.	07/31/2011

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	traumatic stress disorder, and depression. The resident was transferred to another extended care facility on 6/14/11. Nursing notes dated 6/14/11 at 10:45 a.m., indicated Resident #B was discharged and copies of the MAR (Medication Administration Record), POA (Power of Attorney) information, face sheet, notice of transfer and discharge and inventory sheet, were sent with the resident. On 6/28/11 at 10:20 a.m., LPN #1, who discharged Resident #B, was interviewed. LPN #1 indicated, after Resident #B's discharge, the new extended care facility called and requested additional information about the resident. On 6/28/11 at 10:25 a.m., LPN #1 identified the discharge information sent with Resident #B. The resident's diagnoses were not included in the discharge information sent to the new facility. The face sheet and MAR, sent with the resident, had sections for diagnoses but they were blank. On 6/28/11 at 2:00 p.m., the DON (Director of Nursing) indicated, although the facility did not have a policy to send the face sheet and Medication/Treatment records when a resident was discharged to another facility, it was the practice of the facility to send this information.		Resident incurred no negative outcome as a result of the PASRR documentation not being on the chart. 2. a. All residents who are discharged from the facility to either home, the hospital, or to another facility have the potential to be affected. Thus, this POC applies to all residents who will be discharged. b. An audit has been conducted of the MARs and TreatmentAdministration Records (TAR) for all residents to ensure that all medications are being administered according to physician orders. Any identified concerns will be addressed with responsible individuals. c. An audit has been conducted to identify any residents who have gone out of the facility to an appointment, from June 1, 2011, forward to ensure a progress note has been received from the physician, clinic, etc., with the same placed on the medical record. d. A facility wide chart audit has been conducted to ensure that the most recent PASRR documentation is present on all charts. Any concerns identified were promptly addressed. 3. Nursing staff, Social Service staff, and Medical Record staff have received in-service education relative to resident records – complete/accurate/accessible, including but not limited to discharge documentation requirements; documentation of	

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	2. Review of the clinical record for resident (C) on 6/28/11 at 9:45 a.m. indicated the resident had diagnoses including but not limited to Parkinson's, chronic pain, and left sided hemiparesis. Review of the resident's list of medications indicated an order for "Anu-Med suppository" to be given twice daily One on first and second shift. The Medication Administration Record (MAR) for June 2011 indicated no signatures of the resident receiving the suppository on the second shift for June 1, 9, 19, 25, 26, 28 & 30. The record also indicated that on second shift the treatment record had been signed and circled (indicating the resident did not receive the medication) on June 2, 3, 4, 5, 6, 7, 11, 13, 15, 20, 26 and 29. There were two entries made on the back of the record which indicated on 6/20/11 the resident had refused, and on 6/29/11 the documentation indicated "Resident still up at shift change". Interview with the resident on 6/29/11 at 11:00 a.m. indicated that he does not always get the suppository on second shift. Interview with the Director of Nursing on 6/30/11 indicated she knew		medication administration and/or refusal of medications by residents; the importance of obtaining, and filing on the medical record, progress notes from any outside appointments residents have; and placement of preadmission screening conducted by the State on the medical record. A performance improvement tool has been developed that DNS, UM, Social Service staff, Medical Records staff, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, that resident records are complete, accurate, and accessible. Any concerns will be promptly addressed with responsible individuals. 4. DNS, Social Service staff or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.	

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	about the problem and had written a "complaint/grievance" form related to the issue. Review of the form indicated it was dated 6/13/11. 3. Resident #123's record was reviewed on 6/28/11 at 9:50 a.m. The record indicated Resident #123's diagnoses included, but were not limited to, heel ulcer, dementia, and lymph edema. The wound care note, dated 4/13/11, indicated Resident #123 had an unstageable heel ulcer and was to return to the clinic on 5/4/11 at 10:40 a.m. During chart review, no visit note for 5/4/11 was located. An interview was conducted with LPN #1 on 6/29/11 at 10:00 a.m. During the interview, LPN #1 indicated the 5/4/11 visit note had just been faxed. She then provided a copy of the 5/4/11 visit note from the wound clinic with fax information listed as 6/29/11 at 9:49 a.m. 4. Resident #137's record was reviewed on 6/28/11 at 2:40 p.m. The record indicated Resident #137's diagnoses included, but were not limited to, chronic			

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	obstructive pulmonary disease, depression, schizoaffective disorder and lewy body dementia. The admission date listed for the resident was 3/4/08 and readmission dates of 5/24/08 and 9/21/09. During record, the PASAAR in the clinical record for Resident #137 was dated 2008. RN #15 provided a copy of the most recent PASAAR, dated 9/17/10, on 6/30/11 at 11:30 a.m. She indicated the report was located in a binder in the social services office. An interview was conducted with Social Worker #14 on 7/1/11 at 10:30 a.m. She indicated the PASAAR comes to the business office who then gives it to medical records to file in the chart. This Federal tag relates to Complaint Numbers IN00092054 and IN00091583. 3.1-50(a)(1) 3.1-50(h)(6) 3.1-50(a)(3) 3.1-50(f)(2)			

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F9999				
	The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property. Based on interview and record review the facility failed to ensure the inventory sheet was signed at discharge for 2 of 3 closed resident records reviewed. (residents #152 & #154) Findings include: 1. Review of the closed clinical record for resident #154 on 6/28/11 at 2:00 p.m. indicated the resident had discharged from the facility on 6/18/11. There was no inventory sheet in the clinical record which indicated what personal property the resident had on admission and discharge.	F9999	**F9999** 1. 1. & 2. Attempts have been made by nursing facility to contact Resident #s154 and 152, without success. These residents have been discharged from the nursing facility, therefore, no further corrective action can be taken. 2. All residents who are discharged from the facility have the potential to be affected. Thus, this POC applies to all residents who will be discharged. 3. Nursing staff and Medical Records staff have received in-service education relative to ensuring personal inventory sheets are signed upon discharge for all	07/31/2011

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	2. Review of the closed clinical record for resident #152 on 6/30/11 at 9:00 a.m. indicated the resident had died in the facility on 4/8/11. There was no inventor sheet in the clinical record which indicated what personal property the resident had on admission and throughout her stay in the facility. Interview with the Director of Nursing on 7/1/11 at 11:00 a.m. indicated the facility was unable to find the inventory sheets for resident #152 and #154. On 7/1/11 at 11:30 a.m. review of the facility policy "Resident Personal Belongings" indicated under the procedure for discharge: "Have resident (if appropriate), family and/or responsible party sign and date the inventory sheet with the appropriate witness signature upon receipt of personal items." 3.1-9(g)		residents. A performance improvement tool has been developed that DNS,Medical Records staff, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, that resident personal inventory sheets are signed upon discharge. Any concerns will be promptly addressed with responsible individuals. 4. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.	